Cardiovascular Invasive Specialist Certification Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Cardiovascular Invasive Specialist
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee.** This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Education:**
List in date order your educational preparation and post-graduate training. Attach additional pages if you need more space.

☐ **4. Experience:**
List in date order all your professional experience and practice from date of graduation from college or university. Attach additional pages if you need more space.

☐ **5. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional pages if you need more space.

☐ **6. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **7. Applicant’s Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **http://www.doh.wa.gov/hsqa/professions/military/** and include supporting documentation with your application.

Washington State Department of Health

Certification Requirements

In order to qualify for certification you must complete the following requirements:

☐ Application and fee;

☐ Education and examination:

- Graduate from a CAAHEP accredited program; AND
- Successfully pass the national Registered Cardiovascular Invasive Specialist (RCIS) examination administered by Cardiovascular Credentialing International (CCI)

Official Transcripts: Have your school mail your transcripts with the degree and date of graduation listed. Transcripts must come to us directly from the school. Non-posted transcripts or student copies are not acceptable.

Examination Verification: It is your responsibility to ensure that CCI sends official verification of your passing score.

OR

Meet the examination requirements under WAC 246-926-410

Individuals who have been certified or registered with one of the following national organizations shall be considered to have met the education and training requirements:

a. CCI through the RCIS examination;

b. CCI through the Registered Cardiac Electrophysiology Specialist (RCES) examination;

c. Heart Rhythm Society (HRS) through the North American Society of Pacing and Electrophysiology (NASPE) examination; OR

d. American Registry of Radiologic Technologists (ARRT) through the Cardic Interventional Radiographer (RTR-CI) post-primary examination, the Vascular Interventional Radiographer (RTR-VI) post-primary examination, or the Cardiovascular Interventional Radiographer (RTR-CV) post-primary examination.

OR

- Meet the Grandfather Clause requirements
  See Alternative Certification Process—Time Limited

☐ Seven hours of AIDS education and training as required under **WAC 246-12(8)**; AND

☐ Out-of-State Credential Verification form send to the state(s) you are or have held licensure. The state will complete its portion of the verification form and mail it directly back to Washington State.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

Alternate Certification Process—Time Limited Only until 07/01/2012

If you are currently licensed certified, or registered in this state, you may qualify for certification by completing the following requirements:

- Application and fee;
- Verification of Qualifying Experience;
  A minimum of five years of experience as a health care professional; at least a 1000 hours per year for a total of 5000 hours in a five year period.

  Qualifying Experience: Must be in cardiac or vascular catheterization functions as a defined in WAC 246-926-400; have obtained in the last five years; include at least 1000 hours per year; AND be documented on the Verification of Cardiovascular Invasive Specialist Alternative Certification Process—Time Limited Supervised Experience form.
- Seven hours of AIDS education and training as required under **WAC 246-12(8)**; And
- Out-of-State Verification form send to the state(s) you are or have held licensure. The state will complete its portion of the verification form and mail it directly back to Washington State.

Note: Many states charge a verification processing fee. Contact them prior to request to prevent delays in processing.

Other Information:

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial certification will expire on your birthday unless the license is issued within 90 days of your birthday. See **WAC 246-12-020(3)**.
- Certifications must be renewed every year on your birthday as provided in **WAC 246-12(2)**. A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the cardiovascular invasive specialist program is available on our **Web site**.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue

Cardiovascular Invasive Specialist Certification Application

Application for certification as (must check at least one): Requirements Completed:

☐ National examination ..... ☐ (please circle) RCIS, RCES, IBHRE, NASPE, RTR-CI, RTR-VI, RTR-CV
☐ Grandfather Clause..... ☐ Alternate process verification of experience

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)	☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address (if different from above)

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

Facility/Agency Name _____ Phone Number _____

Full Address _____

Indicate current practice setting (example: hospital, clinic, etc.) _____

For Office Use Only

Certification #_____ Registration # _____ Issue Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ..... ☐ ☐
   b. Diverted controlled substances or legend drugs? ..... ☐ ☐
   c. Violated any drug law? ..... ☐ ☐
   d. Prescribed controlled substances for yourself? ..... ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ..... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ..... ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ..... ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

3. Education

List in date order all your education including college or university (pre-radiography, therapeutic and/or nuclear medicine program), and technical or professional practice pertaining to the profession you are applying for. Include all periods of time from the date of graduation from a radiography, therapeutic, and/or nuclear medicine program to present when you engaged in activities related to your practice as a cardiovascular invasive specialist . Attach additional completes pages if you need more space.

Schools Attended Full Name, City and State	Degree/Certificate Earned	Attendance Dates	
		Start (mm/yyyy)	End (mm/yyyy)

4. Experience

List in date order all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

Name of Business	Total Number of Months	Dates	
		Start (mm/yyyy)	End (mm/yyyy)

5. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if current. Attach additional completed pages if you need more space.

State Jurisdiction	Received by		Certificate		Permanent or Temporary	Profession	Currently in Force
	Exam	Other	Year Issued	Number			

6. Aids Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws
(Print applicant name clearly)

of the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, State)

By: _____
(Signature of applicant)

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Washington State Department of Health
Cardiovascular Invasive Specialist
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Alternative Certification Process— Time Limited Supervised Experience Verification

Applicant:

Use a separate form for each supervisor verifying your professional experience. This form may be duplicated. Fill out Section 1 and forward to the supervisor for completion.

1. Print or Type Clearly:

Name: Last	First	Middle	Birthdate (mm/dd/yyyy)
Address			
City	State	Zip Code	

2. Approved Supervisor (Lead Technician, Manager, or Director):

The above individual seeks verification of supervised Cardiovascular Invasive Specialist experience for certification as a Cardiovascular Invasive Specialist. Please complete the following:

Supervisor name	Current phone
Credential State	First Issuance Date
Current Street Address	
City	State	Zip Code

3. Supervised Experience:

Applicant must have a minimum of five years of experience as a healthcare professional; at least a minimum of 1000 hours per year of supervised experience attested to by the catheterization laboratory lead technologist, manager, or director, for a total of 5000 hours for a five year period. Please complete the actual dates and number of hours under your supervision.

Supervision	
Number of hours of supervised experience	Total Hours
Dates of Supervised Experience	From: To:

Supervisor:

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest that I am an approved supervisor as indicate below.

☐ Lead Technician ☐ Manager ☐ Director

Signature:_____ Date: _____

Return this form to the address above.

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Washington State Department of Health
Cardiovascular Invasive Specialist
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

PART 1: Note to applicant

Complete Part 1. Submit form(s) to all state commissions/boards/committees where you have ever been licensed, certified, or registered.

Name _____

I was licensed/certified/registered by the _____ Commission/Board/Committee
State

under the name _____

My original license/certification/registration number is _____

My Address is _____

Signature of applicant _____

PART 2

To be completed by the state commission/board/committee and returned to Cardiovascular Invasive Specialist Credentialing at the address provided above.

License/Certification/Registration issued on _____ Number _____

Applicant licensed by: Exam _____ Endorsement _____ Waiver _____

Status of License/Certification/Registration: ☐ Current ☐ Not Current If not, explain _____

_____

_____

Has license/certification/registration ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, placed on probationary status or under investigation.) ☐ Yes ☐ No If yes, explain _____

_____

(SEAL)

Signature _____

Name/Title _____

State _____

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... **UDA RCW 18.130**

Administrative Procedure Act ..... **APA RCW 34.05**

Administrative procedures and requirements ..... **WAC 246-12**

Cardiovascular Invasive Specialist RCW .....RCW 18.84

Cardiovascular Invasive Specialist WAC.....WAC 246-926

Alternative Education

Alternative Training requirements ..... WAC 246-926-110

AIDS Training Resources ..... **Reference Page**

Online

Cardiovascular Invasive Specialist Program ..... **Web Page**